No. 93-0135

A.D.A. BALL
ROOM 220

Slip #c
14509

Exhibit 19

Commonwealth of Massachusetts

Worcester, ss.

To

Keeper of Records
Medical Center of Central Massachusetts
Memorial Campus
119 Belmont St., Worcester, MA

PLEASE BRING ANY AND ALL RECORDS RELATING TO THE TREATMENT/DIAGNOSIS OF THOMAS KING, D.O.B. 9/27/49 ON OR ABOUT 9/29/92 TO WORCESTER SUPERIOR COURT CLERK'S OFFICE ON OR BEFORE 4/30/93.

Greeting.

In the Name of the Commonwealth, you are hereby required to appear before the Superior Court at Worcester, [redacted] in the County of Worcester, on the XXXXXX day of Friday current, at 30th of the clock in the 9:00 A.M. forenoon; then and there in said court to testify on behalf of said Commonwealth, what you know relative to a Complaint or Indictment there pending against

MICHAEL G. ELBERRY

Hereof fail not, as you will answer your default under the pains and penalties by law in that behalf provided. And the Sheriffs of our several counties, and their Deputies, the State Police Officers of said Commonwealth, and the Constables and Police Officers of any City or Town within said Commonwealth, are in like manner, and under like penalties commanded to make legal service and due return of this process.

Date at Worcester this Friday day of April in the year of our Lord one thousand nine hundred and 2nd 1993

Clerk

A copy. Attest:

Deputy Sheriff.
Court Officer.
State Police.

46 C.P.

FOR FURTHER INFORMATION CALL DISTRICT ATTORNEY'S OFFICE 755-8601

Exh. # 18 4/29/93 C
Identified

8711.1 *Exhibit A-1*

THE MEDICAL CENTER OF CENTRAL MASSACHUSETTS

EMERGENCY

MEDICAL RECORD COPY

TIME IN ROOM: ROOM:

PATIENT'S LAST NAME / FIRST / MIDDLE	MAIDEN NAME	SEX	R	AGE	ACCOUNT NO.	MED. REC. NO.
King Thomas		M	C	43Y	9062373	~~804292~~

PATIENT'S ADDRESS / ZIP	PHONE NO.	MAR.	DATE OF BIRTH	SOCIAL SECURITY NO.	F/C
129 Crescent St Shrewsbury MA 01545	000000	X	09/27/49	014409215	B

PATIENT'S EMPLOYER	EMPLOYER'S ADDRESS	CITY	STATE	ZIP	PHONE NO.
Unknown					

NEXT OF KIN	ADDRESS	CITY	STATE	ZIP	PHONE NO.	RELATION	DATE/TIME OF ARRIVAL
Unkknown Mary Werner					898-3130	Sis	09/29/92 02:

DIAGNOSIS/PATIENT STATES	ATTENDING PHYSICIAN	REL.	ASSIG
L Eye Inj	Misc 298190		

ED ATTENDING	PTP	SERVICE	OCC	REG. CD.	REG. BY	RELIGION	SUBSCRIBER/CO.	LINE
Lemons	E	ER	11		914	NG	Unknown	

INSURANCE CO.	GROUP NO.	CERTIFICATE NO.	SUBSCRIBER	SEX	REL.
1: BLue Cross		009379759	King Thomas	M	PT
2:					
3:					

GUARANTOR NAME	ADDRESS / CITY / STATE / ZIP	PHONE NO.
King Thomas	129 Crescent St Shrewsbury M A 01545	000000

METHOD OF ARRIVAL: Car REFER BY: ID BAND: ☐ YES ☐ NO ALLERGIES: IVP ~~Dye~~ Dye

TRIAGE ASSESSMENT: TIME: 2[10] A TETANUS STATUS: 5-6 yrs Ago LNMP: WGT: BP 130/98 T 98.8 P 92 R 24 VISUAL ACUITY R L

CHIEF COMPLAINT: Someone poked his fingernail thru my

SUBJECTIVE/OBJECTIVE: eyeball - leaking vitreous fluid. Dr O'Connell in to evaluate pt immediately - eye shield applied. Angio #20 started ō difficulty - NS locked + Kefzol hung; WPD into interview pt re: assault. Cousin + sister in c pt. 2[50] Am Dr Arinella into examine pt's eye. 3[35] Am Discharge instructions given and pt left ambulatory c sister and cousin J Glenn RN

CURRENT MEDS: penicillin, othemosene

HEALTH/SOCIAL Hx: carpal tunnel, sinusitus SVT - Afib, blind x 1 yr @ 6yrs old, appy, tonsil, HTN

TIME	BP	P	R	TEMP	PULSE OX

TIME	INIT	MISC TEST
		EKG
		MONITOR
		O_2
		DEXSTICK ____ mg

TIME	RATE	DEVICE	SITE	IV SOLUTION
2[20] A	—	#20	RFA	NS lock
	Betadine prep c aseptic technique			

MEDICATION DOSE & ROUTE	TIME	SITE	RN	MD
Kefzol 1 Gm IV	2[20] A	RFA	JG	
Td-50 0.5cc IM	2[45] A	4	JG	

TIME	INIT	X-RAY	HISTORY	TRANSPORT TYPE TIME IN	TIME OUT

MEDICAL RECORD CALLED ☐ MEDICARE ADV. ☐

SITE CODE: 1 RT. BUTTOCKS 2 LT. BUTTOCKS 3 RT. ARM 4 LT. ARM 5 RT. THIGH 6 LT. THIGH 7 RT. ABDOMEN 8 LT. ABDOMEN 9 & 10 RT/L VENTROGLUTEAL

LAB TEST	TIME	INIT	LAB TEST	TIME	INIT	LAB TEST	TIME	INIT	LAB TEST	TIME	INIT
EG			CHEM 12			THROAT CULTURE			STOOL CULT/O&P		
ALCOHOL			HEPATITIS SCREEN			URINE/URINE C&S			TOX SCREEN		
AMYLASE/LFT			T&H/T&C ____ units			BLD CULT X 2			WET PREP/KOH		
CHEM 7			UCG			GC/CHLAMYDIA			OTHER:		
Mg			HCG/QUANT HCG			SPUTUM CULTURE					
PTT			RAPID STREP			WOUND CULTURE					
CARDIAC ENZYMES											
C/A DIFF/M DIFF											

NURSE'S SIGNATURE J Glenn RN PHYSICIAN'S SIGNATURE

THE MEDICAL CENTER OF CENTRAL MASSACHUSETTS

CONSENT TO RELEASE MEDICAL INFORMATION AND AUTHORIZATION TO PAY INSURANCE BENEFITS

ART I

1. I authorize The Med Center to disclose to my insurance company, Blue Cross, Medicare and/or any other third party payor, medical information contained in the hospital record as may be necessary in order for the Hospital to secure reimbursement for the medical care rendered to me.

2. I voluntarily assign any and all of my rights to payment of benefits payable for any physician services to the physician or organization performing those services at The Med Center.

3. I voluntarily assign any and all of my rights to payment to The Med Center for hospital-based physicians providing professional services in Pathology, Clinical Laboratory, EKG, EEG, and Radioactive Isotopes for the unpaid charges of the physicians, and of benefits otherwise payable to me but not to exceed the hospital's regular charges.

4. I UNDERSTAND THAT IN THE EVENT PAYMENT FOR MEDICAL CARE RENDERED TO ME IS DENIED BY MY INSURER, EMPLOYER, OR ANY OTHER THIRD PARTY PAYOR, I AM FINANCIALLY RESPONSIBLE FOR ALL DEDUCTIBLE AND CO-INSURANCE AMOUNTS AND ALL NON-COVERED CHARGES TO THE HOSPITAL.

Patient Signature _____ Date _____

Witness _____ Date _____

B. The patient is unable to personally consent to the above and to sign this form. Having read and understanding the above provisions, I consent to these statements and authorize the hospital to act in accordance with those provisions.

Signature of Legal Guardian or Closest Relative _____ Date _____

If relative, please state relationship to patient: _____

Witness _____ Date _____

CONSENT FOR TREATMENT

PART II

A. 1. I, _____ (Patient's Name), authorize and request treatment by the professional staff of The Med Center Emergency Department as is deemed necessary for my complaint of _____

2. I understand that I have the right to refuse, discuss, or question any or all tests and/or treatment at any time.

Patient Signature _____ Date _____ Time _____ AM PM

B. The patient _____ (Patient's Name) is unable to personally consent to medical treatment for the complaint stated above because _____

Having read and understanding the above provisions relating to medical treatment of the patient, I consent to medical treatment on the patient's behalf.

Signature of Closest Relative or Legal Guardian _____ Date _____ Time _____ AM PM

Witness _____ Date _____ Time _____ AM PM

C. In the event the patient is unable to consent to medical treatment, and there is no legal guardian or relative available or in existence to consent on the patient's behalf, complete the statement below:

I, _____ (Name of Physician), am of the medical opinion that _____ (Name of Patient) is in need of medical treatment to prevent further serious harm or injury, preserve life and/or to prevent permanent bodily injury or deformity and that further delay in rendering treatment would be harmful to the patient. To my knowledge, unsuccessful attempts have been made to contact the known relatives or legal guardian of the patient..

Physician Signature _____ Date _____

Administrative Approval _____ Date Obtained _____

MEDICAL CENTER OF CENTRAL MASSACHUSETTS

Exhibit A-2

EMERGENCY

MEDICAL RECORD COPY

PATIENT'S LAST NAME	FIRST	MIDDLE	MAIDEN NAME	SEX	R	AGE	ACCOUNT NO.	MED
King Thomas				M	C	43Y	90623793 [illegible]	

TIME | HISTORY/SUBJECTIVE:

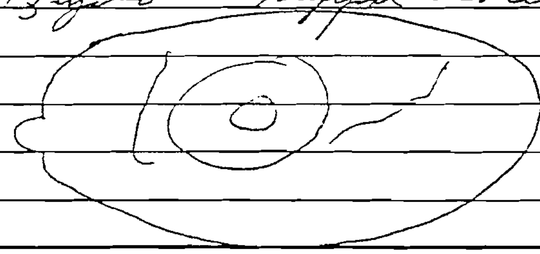
43 y/o police officer states he was working this evening [illegible] while [illegible] at Winners Circle off duty states someone [illegible] + [illegible] pistol [illegible] + got [illegible] finger in left eye [illegible] + blood [illegible]

[illegible]

PHYSICAL EXAM/OBJECTIVE

Eye [illegible]

[illegible]



[illegible]

EVALUATION RESULTS

Globe appears intact.

DIAGNOSIS(ES)/ASSESSMENT

[illegible] laceration [illegible] possible infection + [illegible]

TREATMENT/PLAN (PROCEDURES)

Erythromycin [illegible]

to [illegible]

CONSULTS	TIME CALLED	TIME ANSWERED	DISPOSITION OF CASE	
			☐ POLICE	☐ HOME
			☐ NURSING HOME	☐ WORK
			☐ MORGUE	☐ TRANSFER
			☐ ME NOTIFIED	☐ ADMITTED
			☐ AMA	ROOM NO.

CONDITION OF PATIENT

☐ IMPROVED ☒ SAME ☐ WORSE ☐ EXPIRED

INFORMATION SHEETS GIVEN: WOUND CARE, HEAD INJURY, ABDOMINAL, NAUSEA, VOMITING AND DIARRHEA, FEVER, SPRAINS, FRACTURES, X-, BLOOD PRESSURE, BACK AND NECK INJURIES, COLD AND SORE T-, OTHER.

INSTRUCTIONS

to [illegible] at 591 [illegible] St [illegible]

FOLLOW-UP

I HAVE RECEIVED AND UNDERSTAND THE INSTRUCTIONS INDICATED ABOVE. I UNDERSTAND THAT I HAVE HAD EMERGENCY TREATMENT ONLY, AND T- MAY BE RELEASED BEFORE ALL MY MEDICAL PROBLEMS ARE KNOWN OR TREATED. I WILL ARRANGE FOR FOLLOW-UP CARE AS INDICATED ABOVE.

TIME X Thomas [illegible] King

SIGNATURE OF PATIENT | SIGNATURE OF PHYSICIAN | SIGNATURE OF ATTENDING PHYSICIAN

THE MEDICAL CENTER OF CENTRAL MASSACHUSETTS

MEMORIAL

119 Belmont Street
Worcester, MA
01605-2982

(508) 793-6611
FAX (508) 793-6324

This is to certify that the attached is a true record of this hospital concerning the treatment of:

THOMAS KING

"SUBSCRIBED AND SWORN TO UNDER THE PAINS AND PENALTIES OF PERJURY."

TOTAL NUMBER OF PAGES:

3

Natasha Narain

NATASHA NARAIN

04/30/93